EXHIBIT D

Witches, multiple personalities, and other psychiatric artifacts

Contemporary psychiatric misdirections derived primarily from standard medical errors of oversimplification, misplaced emphasis, and invention are reviewed. These particular errors, however, were in part prompted and sustained by the sociocultural fads and fashions of the day. The results have been disastrous for everyone — patients, families, the public and psychiatry itself.

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Psychiatry is a medical discipline long on disorders and short on explanations. Just a glance at the *Diagnostic and Statistical Manual* now in its fourth edition (DSM-IV) will confirm this verdict. DSM-IV presents hundreds of psychiatric disorders arranged according to their symptoms—depression, anxiety, schizophrenia and the like—but quite scrupulously avoids an etiological arrangement. Its authors are aware that psychiatrists tend to split up into camps, based on purported explanation — hence, biological, dynamic, behavioural, and even the eclectic — and go to war with one another.

However, this shortage of agreed-upon explanations brings good news and bad news. The good news is there is plenty of room for useful scientific research in psychiatry and a great deal of this is going on at the moment[1]. The bad news is, because practitioners in this discipline are hungry for explanations today, at least once each decade, psychiatry is swept by an enthusiasm for a fundamentally incoherent practice, and then must spend at least ten years subsequently digging out of the troubles that this practice produced. These misdirections of psychiatry rest squarely on standard medical mistakes such as oversimplification, misplaced emphasis or pure invention. The enthusiasms for these misdirections, however, usually derive from an uncritical acceptance of transient cultural attitudes and fashionable ideas. The repeated combination of these elements proves how all too often the discipline of psychiatry has been the captive of culture, to the detriment of everyone.

Anti-psychiatry

The most conspicuous misdirection of psychiatric practice — the precipitate dismissal of patients with severe, chronic mental disorders such as schizophrenia, from psychiatric hospitals — required a vastly oversimplified view of mental illness. Ironically, these actions were defended as efforts to bring 'freedom' to these people, sounding a typical 1960s cultural theme that marched right by the fact that it was the patients' illnesses that had deprived them of freedom in the first place. There were several collaborators in this sad enterprise. Prominent among them were state governments looking for release from the traditional but heavy fiscal burden of housing the mentally ill. Crucial to the process was the combination of fashionable opinions of the era about society's institutions as oppressive and oversimplified explanatory opinions about schizophrenia and other mental illnesses generated by the so-called anti-psychiatrists, Thomas Szasz, R.D. Laing, Erving Goffman, and Michel Foucault, notably among them.

A simple description of the mental problems of psychiatric patients was not the style of our 1960s commentators. They were more interested in painting a picture of their own devising. A picture that would provoke first suspicion and then disdain for contemporary psychiatric practices. And it did so, not by producing new standards or reforming specific practices, but by ridiculing and caricaturing efforts of the doctors and the institutions, just as fashion directed. The power of scorn was surprising and had amazing results, leading many in the public and not a few in the profession to believe that it was the institutions that provoked the patients' troubles rather than illness that called out for shelter and treatment. Here from Szasz's book, *Schizophrenia — The Sacred Symbol of Psychiatry*[2], is a typical comment: "The sense in which I mean that Psychiatry creates schizophrenia is readily illustrated by the analogy between institutional psychiatry and involuntary servitude. If there is no slavery there can be no slaves . . . . Similarly if there is no psychiatry there can be no schizophrenics. In other words, the identity of an individual as a schizophrenic depends on the existence of the social system of (institutional) psychiatry."

Effective replies to such commentary demanded knowledge first of the patients themselves, in schizophrenia, people impaired by delusions, hallucinations and disruptions of thinking capacities, but also understanding of how the concept of disease has, essentially since Sydenham, provided physicians with a coherent, logical, and stepwise approach to human afflictions, from symptom clusters to etiology, ultimately. The disparagement of this approach by the likes of Szasz demonstrated an ignorance of the explanatory potential of the concept of disease right from the start.

A saving grace for any medical theory or practice (the thing that spares it perpetual thralldom to the gusty winds of fashion) is the patients. They are real, they are around and a knowledge of their distressing symptoms guards against oversimplification. The claim that schizophrenic patients are in any sense living an alternative life style that our institutions were inhibiting was fatuous. Every urban citizen now recognizes, because of a familiarity with the many homeless people that the anti-psychiatric fad generated, that these patients have impaired capacities to comprehend the world and that they need protection and serious active treatment.

As well, and fortunately, the enterprises of brain research launched subsequent to these pronouncements have documented a cerebral source for many of the particular symptoms of schizophrenia[3,4]. This research tends to confirm that the conceptual model of epilepsy that helped sort out that condition (distinguishing symptomatic epilepsies, caused by some coarse brain pathology, from the idiopathic epilepsies, that rest upon genes) also makes sense of the group of conditions called schizophrenia[5]. The ultimate solutions for the homeless mentally ill are still to

be found but, as the saying goes, the anti-psychiatrists are history.

A question of gender

A similar combination of a cultural fad amidst a dearth of explanations led to the grim practice of sex reassignment surgery in the 1970s. I happen to know about this because Johns Hopkins was one of the places in the United States where this practice, with what at the time were called transsexuals, was given its start.

Typically a man comes to the clinic and says something like, "As long as I can remember, I've thought I was in the wrong body. True, I've married and had a couple of kids but always, in the back and now more often in the front of my mind, there's this idea that actually I'm more a woman than a man. I'm here because all this male equipment is disgusting to me. I want medical help to change my body: hormone treatments, silicone implants, surgical amputation of my genitalia and the construction of a vagina. Will you do it?"

. . . psychiatrists do not understand what is the problem here but hope surgery may do the poor wretch some good.

The patient claims it is a torture for him to live as a man, especially now that he has read in the newspapers about the possibility of switching surgically to womanhood. Upon examination it is not difficult to identify other mental and personality difficulties in him, but he is primarily disquieted because of his intrusive thoughts that his sex is not a settled issue in his life.

The skills of our plastic surgeons, particularly on the genitourinary system, are impressive. They were obtained, however, not to treat a presumptive gender identity problem but to repair congenital defects, injuries and the effects of destructive diseases such as cancer in this region of the body. That you can get something done doesn't always mean that you should do it. There are so many problems right at the start. In sex reassignment cases, the patient's claim that this has been a lifelong problem is seldom checked with others who have known him since childhood. It seems so intrusive and untrusting to discuss the problem with others even though they might provide a better gauge of the seriousness of the problem, how it emerged, its fluctuations of intensity over time and its connection with other experiences. When you discuss what the patient means by "feeling like a woman," you often get a sex stereotype in return and something that female physicians note immediately as a male caricature of women's attitudes and interests. One of our patients, for example, said that, as a woman, he would be more "invested with being than with doing."

Experts say that a sense of one's own maleness or femaleness rests upon a complicated biopsychological process and suggest that some derangement in this natural process may be the explanation for this problem. They venture that, although their research on those born with genital and hormonal abnormalities may not apply to a person with normal bodily structures, something must have gone wrong in this patient's early and formative life to cause him to feel as he does. Why not help him look more like what he says he feels? Our surgeons can do it.

On the other hand it is not obvious how this patient's sense that he is a woman trapped in a man's body differs from the feelings of a patient with anorexia nervosa that she is obese despite her emaciated, cachectic state. We don't do liposuction on anorexics. So why amputate the genitals of these patients? Surely, the fault is in the mind, not the member.

A plastic surgeon at Hopkins provided the voice of reality on this matter based on his practice and his natural awe at the mystery of the body. One day while we were talking about it, he said to me: "Imagine what it's like to get up at dawn and think about spending the day slashing with a knife at perfectly well formed organs, because you psychiatrists do not understand what is the problem here but hope surgery may do the poor wretch some good."

The zeal for this sex change surgery did not derive from critical reasoning or thoughtful assessments. The energy came from the fashions of the 1970s that invaded the clinic. If you can do it and he wants it, do it. This fashion was intregal to an aesthetic that saw diversity as everything, and could accept any idea, including that of surgical sex change, as interesting, and resistance to such ideas as uptight or even oppressive. Yet, moral matters should have some salience here. These include the confusions imposed on society where these men/women insist on acceptance even in athletic competition with women; the encouragement of the 'illusion of technique' which assumes that the body is like a suit of clothes to be hemmed and stitched to style; there is the ghastliness of the mutilated anatomy to consider; and finally, consider that this surgical practice has distracted effort from genuine investigations attempting to find out just what has gone wrong for these people. What has, by their testimony, given them years of torment and psychological distress and prompted them to accept these grim and disfiguring surgical procedures.

We now appreciate that this condition falls into the category of "overvalued ideas"[6] described very thoroughly by Carl Wernicke[7] at the beginning of the century. This is a category that includes morbid jealousies, anorexia nervosa and litigious personalities. Fortunately the diagnostic term transsexualism has been abandoned and replaced with the term Gender Identity Disorder making it clear that the problem is one of ideas rather than of bodily constitution and should be treated as such.

Psychiatrists collaborated in an exercise of folly with distressed people. and a misplaced emphasis proved hazardous when explanations were at a premium.

Artifactual behaviour

Medical errors of oversimplification and misplaced emphasis usually play themselves out with consequences all can see. Pure inventions can bring out a darker, hateful potential when psychiatric thought goes awry in search for an explanation. Most psychiatric histories choose to describe such invention by detailing its most vivid example — witches. The experience in Salem, Massachusetts, of 300 years ago is prototypical[8].

Briefly, in 1692, several young women and girls who had for some weeks been secretly listening to tales of spells, voodoo, and illicit cultic practices from a Barbados slave suddenly displayed a set of mystifying mental and behavioural changes. They developed trance-like states, falling on the ground and flailing, and screaming at night and at prayer, seemingly in great distress and in need of help. The local physician, who witnessed this, was as bewildered as anyone else and eventually made a diagnosis of "bewitchment". "The

evil hand is on them", he said and turned them over to the local law officials for examination and ultimately for protection. The clergy and magistrates assumed, taking their lead from the doctor, that local agents of Satan were at work and, using as grounds the answers of these young women to leading questions, indicted several citizens for bewitching them. The accepted proof of guilt was bizarre. The young women spoke of ghostly visitations by the defendants to their homes to torment them, all occurring while the accused were known by the testimony of reliable witnesses to be elsewhere. The victims often screeched out in court that they felt the accused pinching them even as everyone could see the defendants sitting quietly on the other side of the court room. Strange as it seems this testimony had great weight because the judges and the juries believed that capacities of this kind — provoking injury from a distance or being in two places at the same time — were skills and powers of witches. On the basis of this "spectral" evidence they dismissed all protests of innocence by the defendants and promptly executed them. The whole exercise should have been discredited when, after the executions, there was no change in the distraught behaviour of the young women. Instead more and more citizens were indicted. Eventually, good sense began to prevail, in part because many citizens came to recognize that no one was safe against these accusations and in part because a prosecution depending on spectral evidence was recognized to be as irrefutable as it was undemonstrable. The trials ceased and ultimately several of the young women admitted that their beliefs had been "delusions" and their accusations false.

A psychiatric or psychological artifact . . . is a product of human crafting.

The proper psychiatric diagnosis for those young women is, of course, not bewitchment but any of a series of terms such as hysteria, factitious disorder or malingering, all attempting to communicate the view that the mental states and behaviours of these individuals should be recognized as artifacts. A psychiatric or psychological artifact, like a physical artifact, is a product of human crafting. It is not a product of nature, such as a disease, but something manufactured by some person or persons for some human purpose or action. Behavioural displays in which physical or mental disorders are imitated (artifactual clinical disorders) are common enough on any medical service. On inspection, the patient's manufactured imitations of illness derive from a variety of different sources of information and suggestion, and they serve a variety of personal goals. In this era artifactual clinical conditions usually represent an effort on the part of a troubled person to take on the sick role with the benefits of care, attention and support this status brings to an individual. The status of 'bewitched' in Salem of 1692 brought both attentive concern and the license to indict any enemy to young women previously scarcely noticed by the community.

Forms of artifactual behaviour whether they are physical activities, such as falling and shaking, or mental phenomena, such as pains, visions or memories are partially shaped by unintended suggestions from others and sustained by the attention of onlookers and especially onlookers such as doctors who are socially empowered to assign, by affixing a diagnosis, the status of patient to a person. Whenever a diagnostician mistakes an artifact for what it is attempting to imitate by misidentifying the artifact either as some natural process, such as epilepsy, or inventing some specious explanation for it, such as bewitchment, then the behavioural display will continue, expand, prove treatment resistant and, in certain settings, spread to others. The usual result is trouble. Over the last decade a remarkable example of manufactured artifactual behaviour has surfaced and has been misidentified and bolstered by an invented view of its cause that fits a cultural fashion. This condition is Multiple Personality Disorder (MPD).

Today's awful version of psychiatric invention is the notion that many people suffered sexual abuse — if only they remembered.

Multiple personality disorder

Patients who are eventually diagnosed as suffering from MPD come to therapists with standard psychiatric complaints such as depression or anxiety. Some therapists see much more in these symptoms and suggest to the patient, and to others, that the symptoms represent the subtle actions of several alternative personalities, alters, coexisting in the patient's mental life. These suggestions encourage many patients to see their problems in a new light. Suddenly they are transformed into odd people with repeated shifts of demeanor and deportment that they display on command and sometimes in response to hand signals from the therapist. An artifactual behaviour has been generated by the combination of the vulnerabilities of the patient to suggestion and the beliefs of the therapists.

Sexual politics in the 1980s and 1990s, particularly about sexual oppression and victimization, galvanizes these inventions. Forgotten (repressed) sexual mistreatment is the proffered explanation of MPD. Just as an epidemic of bewitchment served to prove the arrival of Satan in Salem, so in our day an epidemic of MPD is used to propose that a vast number of adults were sexually abused by guardians during their childhood, the MPD being one of the presumed expressions of the traumatic experience. Now, I do not for a moment deny that children are sometimes victims of sexual abuse or that such abuse would produce psychiatric symptoms. Such realities are not at issue. What I am concerned with here is what has been imagined from these realities and inventively applied.

Adults with MPD, so theory goes, were assaulted as young children by a trusted and beloved person, usually a father although grandfathers, uncles, brothers, or others, often abetted by women in their power, are also possibilities. This sexual assault, the theory holds, is blocked from memory (repressed and dissociated) because it was so shocking. This dissociating blockade itself is purported to destroy the integration of mind and evokes multiple personalities as separate, disconnected, sequestered, 'alternative' collections of thought, memory and feeling. These resultant distinct 'personalities' produce a variety of what might seem standard psychiatric symptoms, such as depression, weight problems, panic states or demoralization, that only careful review, by experts on psychic life, will reveal to be expressions of MPD and the outcome of sexual abuse.

These patients have not come to treatment reporting a sexual assault in childhood. Only as the therapy is developed is the possibility that they were sexually abused as children suggested to them. From recollections of the mists of childhood, a vague sense of vulnerability may

slowly emerge, facilitated and encouraged by the treating group. This sense of vulnerability is thought a harbinger of clearer memories of victimization that, although buried, have been active for decades producing the different 'personalities'. The long 'forgotten' abuse is finally 'remembered' after sessions of 'uncovering' therapy, during which long conversations take place, often enhanced by sodium amytal or by hypnotic inductions, between the therapist and alter personalities, personalities that usually will be of all age ranges, differing sexes and not uncommonly animals that must also be made to speak.

Any actual proof of the provocative sexual assault is thought unnecessary since the presence of the MPD is thought proof enough. Theory about how the mind works and how its manifestations are to be understood is considered quite adequate to accuse the patient's parents of vile and atrocious acts against the patient when she (some 85% are women) was a child, with nothing more than this new form of spectral evidence, evidence that is just as irrefutable as that at Salem.

The idea of MPD and its cause has caught on among large numbers of psychotherapists. Its partisans see the patients as victims, cosset them in groups, encourage more expressions of alters (up to as many as 100 or more), and are ferocious towards any defenders of the perpetrators of the abuse. Just as the divines of Massachusetts were convinced that they were fighting Satan by recognizing bewitchment, so the contemporary divines, these therapists, are confident that they are fighting sexual oppression and child abuse, by recognizing MPD. The incidence of MPD has of late taken on epidemic proportions particularly in certain treatment centers. Whereas its diagnosis was reported less than 200 times from a variety of supposed causes prior to 1970, it has been applied to more than 20,000 people in the last decade and largely attributed to sexual abuse.

I have been involved, either directly or indirectly, with more than thirty such cases in the last few years. In every one, the very same story has been played out in a stereotyped script-like way. In each, a young woman with a rather straightforward set of psychiatric symptoms (depression and demoralization) sought psychotherapeutic help and her case was stretched during a course of therapy into a diagnosis of repressed memories of sexual abuse, a delayed form of Post Traumatic Stress Disorder and usually MPD. In each case, an accusation of prior sexual abuse was levelled by her, usually against her father but in about thirty percent of cases against the mother. The accusation developed, always after the onset of therapy, first as vague feelings of dream-like childhood reminiscences of danger and darkness and eventually crystallizing, sometimes in a flash, into a recollection of father forcing sex upon the patient as a child. No other evidence of these events was presented. Refuting testimony, coming from former nursemaids or the other parent for example, was dismissed if presented.

On one occasion, the identity of the molester changed. This change was as telling about the nature of evidence as was the emergence of the original charge. A woman called her mother to

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The Salem witch trial

claim that she had come to realize that when she was young she was severely and repeatedly sexually molested by a maternal uncle. The mother questioned the daughter about the dates and times of these incidents to determine if they were even possible. She soon discovered that her brother was on military service in Korea at the time of the alleged abuse and with this information, the mother went to her daughter with the hope of showing her that her therapist was misleading her in destructive ways. When she heard this new information, the daughter seemed momentarily taken aback, but then said, "I see, Mother. Yes. Well, let me think. If your dates are right, I suppose it must have been Dad." And with that, she began to claim that she had been a victim of her father's abusive attentions and nothing could dissuade her.

The accused parents whom I studied, denying the charges and amazed at their source, submitted to detailed reviews of their sexual lives and any other efforts up to and including polygraphic testing to try to prove their innocence. Professional requests by me to the daughters' therapists for better evidence of the abuse were dismissed as derived from the pleadings of the guilty and were deemed beneath contempt given that the diagnosis of MPD indicated, and the ultimate testimony of the patient's patently confirmed, the sex abuse.

Remembered trauma

In Salem, the convictions of the defendants depended on how judges thought witches behaved. In our day, similar convictions depend on how some therapists think memory of trauma customarily works. In fact, standard psychiatric teaching in the past held that severe traumas are usually remembered all too well. They are amplified in consciousness, remaining like grief to be reborn and re-emphasized on anniversaries and in settings that can simulate the environments where they occurred. Good evidence for this was found in the memories of children from concentration camps. More recently, the children of Chowchilla, California, who were kidnapped in their school bus and buried in sand for many hours, remembered every detail of their traumatic experience years later and needed psychiatric assistance, not to bring out forgotten material that was repressed but to help them move away from a constant ruminative preoccupation with the experience[9].

Many psychiatrists upon first hearing of these diagnostic formulations (MPD being a form of post traumatic stress and the result of repressed memories of sexual abuse in childhood) have fallen back upon what they think is an even-handed way of approaching it. The mind is very mysterious in its ways, they say, anything is possible in a family. In fact, this credulous stance towards evidence and the failure to consider the alternative of artifactual behaviours, memories and beliefs continue to support this crude psychiatric analysis, and if the kinds of practices that lie behind the diagnosis of MPD become standard in psychiatry, then no family with a member in psychotherapy is safe from a persecution galvanized by the same kind of energy and reasoning that launched the witches' court or the lynch mob.

The helpful clinical approach to the patient with putative MPD, as with any instance of an artifactual display, is to direct attention away from the manufactured behaviour — one simply never talks to an alter. Within a few days of a consistent therapeutic focus away from the MPD behaviour and on to the issues of depression and anxiety that were the presenting matters, preoccupations with alters and supposed repressed memories fade and generally useful psychotherapy begins.

This epidemic will end in the same way that the witch craze ended in Salem. The MPD phenomena will be seen as manufactured, the 'repressed memory' explanations will be recognized as misguided, and psychiatrists will become immunized against the practices that generated these artifacts[10]. Meanwhile, time is passing, many families are being hurt and confidence in the competence and impartiality of psychiatry is eroding.

A time to learn

Major psychiatric misdirections often share this intimidating mixture of a medical mistake and a trendy idea. Any challenge to such a misdirection must confront simultaneously the professional authority of the proponents and the political power of fashionable convictions. Such challenges are not for the fainthearted or inexperienced. They seldom quickly succeed because they are often misrepresented as ignorant or, in the cant word of our day, uncaring.

In ten years much damage can be done, and much effort over a longer period of time is required to repair it. Thus with the mentally ill homeless, only a new crusade and social commitment will bring them adequate psychiatric services again. Age increases the sad caricature of the sexual reassigned and saps their bravado. Some, pathetically, even ask about re-reassignment. And groups of parents falsely accused of sexual mistreatment by their grown children are gathering together to fight back against psychotherapists in ways that are producing dramatic but distressing court room spectacles. How good it would have been if all these misguided programs had been avoided or at least their span abbreviated.

Psychiatry is a medical discipline. It is capable of medical triumphs and serious medical mistakes. We don't know the secret of human nature. We cannot build the New Jerusalem. We can describe how our explanations for mental disorders are devised and develop, and where they are strong and where they are limited. We can clarify the presumptions about what we know and how we know it. With more research, steadily, we can construct a clinical discipline that, while delivering less to fashion, will bring more to patients and their families.

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